Continuing Education Module

Many Women and Providers Are Unprepared for an Evidence-Based, Educated Conversation About Birth

Michael C. Klein, MD, CCFP, FAAP (Neonatal–Perinatal), FCFP, ABFP, FCPS

ABSTRACT

Findings from recent Canadian studies on the knowledge and beliefs about birth practices among first-time pregnant women and among obstetricians and other birth providers indicate that many women are inadequately informed and many providers deliver non-evidence-based maternity care. Consequently, informed decision making is problematic for pregnant women and their providers. New strategies are needed to inform pregnant women about key procedures and approaches that might be used in birth so they can have an educated, shared discussion with their provider and successfully advocate for their preferred birth experience. In addition, providers can be encouraged to supplement their knowledge with current, evidence-based maternity care practices. To avoid a lack of informed decision making and to ensure that natural, safe, and healthy birth practices are based on current evidence, pregnant women and providers must work together to inform themselves and to add childbirth to the women's health agenda.

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MANY WOMEN ARE UNPREPARED FOR AN EVIDENCE-BASED DISCUSSION WITH THEIR PROVIDER

In our Canadian national study of women approaching their first birth, my colleagues and I found that a substantial number of women, even late in pregnancy, were uninformed about the risks and benefits of key procedures and approaches that might be used in birth (Klein, Kaczorowski, et al., 2011). We examined the knowledge and beliefs about birth technology among 1,318 Canadian women approaching their first birth. Forty-three percent were under the care of an obstetrician, 29% of a family physician, and 28% of a registered midwife. Only 30% of the women had attended childbirth education classes; books and the Internet were their main sources of information. Women attending obstetricians were more favorable to birth technology and less supportive of women's roles in their own birth experiences. Women attending midwives were less favorable to the use of technology and more supportive of women's roles in their birth experiences.

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Family practice patients' viewpoints fell between the two other groups. "I don't know" responses ranged from 30%–50%, most frequently for questions regarding the risks and benefits of epidural analgesia, cesarean surgery, and episiotomy. Women in the care of midwives consistently used "I don't know" options less frequently than women cared for by physicians.

The women's lack of evidence-based knowledge about epidural analgesia included failure to appreciate that it interfered with labor and was associated with an increase in the use of forceps and vacuum. Many were unaware of the benefits and risks of cesarean surgery, including whether it was associated with urinary incontinence or sexual issues. The women's knowledge was also insufficient about the benefits and risks of episiotomy, the role of doulas in improving outcomes for mother and baby, and the place and mode of birth, including a birth center or home birth.

Throughout the three trimesters, women attending midwives demonstrated more evidence-based knowledge than women attending physicians. It was clear that women attending midwives had "researched" their choice of birthing care, which demonstrated a high degree of concordance between what women attending midwives believe and what midwives also believe.

SYNCHRONY WITH PROVIDER ATTITUDES?

Our Canadian national study of providers' attitudes and beliefs demonstrated that many providers, especially obstetricians, have several non-evidence-based views (Klein et al., 2009). Twenty percent of obstetricians believed that cesarean surgery was as safe or safer for mothers and babies as vaginal birth. Half of obstetricians were not supportive of doulas, and 70%–80% of providers felt that home birth was unsafe. Epidural analgesia was another area where many providers, especially obstetricians, felt that the procedure did not interfere with labor or increase the frequency of instrumental birth. It is important to recognize, however, that up to 20% of obstetricians had attitudes that aligned with midwives; thus, although obstetricians, as a group, may be attached to the routine or regular use of technology in normal birth, a significant minority of obstetricians feel otherwise.

Obstetricians in the younger group were less favorable to birth plans, less likely to acknowledge the importance of the woman's role in her own birth experience, and more likely to view cesarean surgery as "just another way to have a baby."

In our subsequent, more recent study on providers' attitudes, my colleagues and I divided obstetricians into two groups, according to their age: younger than 40 years old and older than 40 years old (Klein, Liston, et al., 2011). We learned that the obstetricians in the younger group—81% of whom were women—were more likely than the obstetricians in the older group to feel that epidurals did not interfere with labor; that cesarean surgery protected against pelvic floor dysfunction, sexual problems, and urinary incontinence; and that cesarean surgery was safer for mother and baby. In addition, compared to participants in the older group, more participants in the younger group were planning for themselves, or for their partner, not to experience vaginal childbirth. Perhaps most concerning, the obstetricians in the younger group were less favorable to birth plans, less likely to acknowledge the importance of the woman's role in her own birth experience, and more likely to view cesarean surgery as "just another way to have a baby." They were also more likely to believe that women who had cesarean surgery "did not miss an important life event." It is important to emphasize that the viewpoints of participants in the younger group are not about gender but about generation; meaning, the younger male obstetricians expressed views similar to the female obstetricians in the younger group.

Taking the woman's study and provider's studies together, it raises the question of how informed decision making can take place when so many women approaching their first birth are ill-informed and so many providers think they know, but what they believe is not evidence-based. That, together with the obvious power imbalance, places many women in a vulnerable position—they are not equipped to advocate for themselves.

CHILDBIRTH AND THE WOMEN'S HEALTH AGENDA

Childbirth is not on the women's health agenda in most Western countries (e.g., see World Health Organization, 2009). It never has been. Osteoporosis is.

Breast health is; violence against women is. Why not childbirth? Because women, understandably, do not want to be judged only by their reproductive capacities. Women are multipotential people. Among many potentialities, they can rise to the top of the academic and corporate world. Giving birth is just one of many things that women can do. But now is the time to add childbirth to the women's health agenda; it is because of the lack of informed decision making that birth should be added to that agenda, lack of information, misinformation, and even disinformation. The time is now.

In the 1970s and 1980s, women fought a revolution to allow partners (we used to call them "fathers") into the birth room, to eliminate shaving and enemas, and to reduce routine episiotomy. Birth rooms with paisley wallpaper and equipment hidden behind cabinets were a part of their demands. We called the result of that revolution "Family-Centered Maternity Care." Today, Family-Centered Maternity Care is pretty much nothing more than marketing. What really matters is attitudes and beliefs, which are much more difficult to change than putting away the scissors and hanging some plants. These are systemic issues. It is all about anxiety and fear. The doctors are afraid (Klein, 2005). The women are afraid (Klein, Kaczorowski, et al., 2011). Society is afraid and averse to risk.

So how can you make a revolution when so few individuals are unhappy with current maternity care practices? The most unhappy and well-informed women select midwives, if available. The most fearful women select obstetricians. Providers are not going to initiate the revolution to make childbirth a normal rather than a high-risk, industrialized activity. *The problem is not that obstetricians are surgeons. They are. The problem is that society has invested surgeons with control over normal childbirth*. Women are going to have to take the lead in providing themselves with the needed information to have an educated conversation with whoever is following them in pregnancy and attending their birth. Evidence-based Web sites are needed, and my colleagues and I are in the process of evaluating the available Web sites and Internet information. It is a huge task, but good sources of information are out there. We have to figure out how to get quality information into the hands of a vulnerable population of women in a format that works for them.

A final note: Lest you think that Canadian data do not apply to the United States, despite huge differences in the way health care is organized, cesarean surgery rates are similar in both countries; moreover, both countries are low on the list of optimal perinatal and maternal outcomes, and for the first time, perinatal and maternal indices are going in the wrong direction. The educational models are similar on both sides of the U.S.–Canadian border, and education trumps evidence; educational models that teach that childbirth is an accident waiting to happen are common in both countries.

Now is the time to add childbirth to the women's health agenda; it is because of the lack of informed decision making that birth should be added to that agenda.

Dr. Klein is a regular contributor to Science & Sensibility, *Lamaze International's research blog (www.scienceandsensibility.org). Visit the blog to read more viewpoints from Dr. Klein and to join in the discussion.*

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MICHAEL C. KLEIN *is emeritus professor of family practice and pediatrics at the University of British Columbia in Vancouver, Canada. He is also senior scientist emeritus at the Centre of Developmental Neuroscience and Child Health in the Child and Family Research Institute and Women's Health Research Institute, in Vancouver. In addition to numerous awards he has received over the years for his research on primary care and family practice, Dr. Klein received the Irwin Chabon Award in 2007 from Lamaze International in appreciation of his research and his strong voice in support of natural, safe, and healthy birth.*